

## Basal Cell Carcinoma

General: Common skin cancer arising from basal layer of epidermis with a generally low metastatic potential, however with often locally invasive properties to surrounding structures.

### Epidemiology:

- 2-3.5 million treated lesions in last year
- 40 percent of patients with one BCC will develop another within 5 years
- Older (>55) white male living in equatorial areas

### Risk Factors:

- Sun exposure – childhood exposure more important than adult?
- Susceptibility to solar radiation – fair skinned, older age, high number of past sunburns
- Arsenic exposure
- Immunosuppression – SCC>BCC

### Symptoms:

- 70% on the face (solar exposure), 15% on the trunk
- Nodular (60%, flesh colored papule), Superficial (30%, scaly red papule or plaque), and morpheaform (5-10%, lightly erythematous papules or plaques atrophic with ill defined borders)

### Diagnosis:

- Histologic!

### Treatment:

- The risk for lesion recurrence influences the approach to treatment – low likelihood managed with ED +C or surgical excision
  - Low likelihood: location <6 mm in diameter in high risk, nodular or superficial histopathologic growth, primary lesion, well defined borders, immunocompetent with no radiation history
- 1. ED+C: Used most often on lesions on trunk and extremities. 5 year recurrence rate 13-18%. Avoid use in mid-face due to shallow tissue planes and susceptibility to tumor invasion. Ease, rapidity, low cost, easily tolerated.
- 2. Surgical excision: Five year cure rates exceeding 95%. 4mm margins used. Fast, inexpensive, provides info on margins.
- 3. Topical: superficial BCCs in noncritical areas (imiquimod, 5-FU)
  - High likelihood: Mohs micrographic surgery to optimize margin collection

### Prognosis:

- Metastases 0.0029 to 0.55 percent.
- Recurrence rate of 40 percent in 5 years.
- Increased risk of melanomas (2x's the population) and SCC (5-10%)
- F/u recommended every six months for one year, then annually.